

Comparison of H.R. 2563 and Pending Medicaid Patient Protections

1. Emergency Access

In a speech to the American College of Cardiology in March, President Bush declared, “We must guarantee *all patients*...the right to get emergency treatment at the nearest emergency room.”¹ Consistent with this view, H.R. 2563 includes provisions to protect patients from managed care abuses in the event of a medical emergency.

Specifically, the bill prohibits plans from requiring patients to obtain pre-approval before seeking emergency care.² Plans also must pay for emergency care, as long as the patient suffers from a:

“medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.”³

The Social Security Act then defines these conditions as:

“(A) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
(B) Serious impairment to bodily functions; or
(C) Serious dysfunction of any bodily organ or part.”⁴

Identical protections are part of the pending Medicaid rules. Health plans would be required to tell enrollees that “prior authorization is not required for emergency services.”⁵ Again, plans cannot refuse to pay for emergency care when a patient suffers from a:

¹Remarks by the President to the American College of Cardiology Annual Convention. March 21, 2001. (<http://www.whitehouse.gov/news/releases/2001/03/20010321-2.html>)

²H.R. 2563, Section 113(a)(1)(A)

³H.R. 2563, Section 113(a)(2)(A)

⁴42 USC 1396u-2(b)(2)(C)(i)-(iii).

⁵42 CFR 438.114(b)(2)

“medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in--

- (A) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- (B) Serious impairment to bodily functions; or
- (C) Serious dysfunction of any bodily organ or part.”⁶

2. Specialty Care

President Bush recently said, “We must guarantee *all patients*...the right to see a specialist when they need one -- say, just for an example, the right to see a cardiologist for a heart problem.”⁷

H.R. 2563 provides four key protections for individuals needing specialty care. First, the bill mandates that “participants, beneficiaries and enrollees receive timely access to specialists...when such specialty care is a covered benefit under the plan or coverage.”⁸ Second, managed care plans must provide for specialty care outside of the network when needed.⁹ Third, patients are entitled to “standing referrals” when appropriate, so that they do not have to repeatedly get permission from a primary care physician to see a specialist.¹⁰ Fourth, when conditions are “life-threatening, degenerative, potentially disabling or congenital” and require “specialized medical care over a prolonged period of time,” patients have the right to have their care for that condition directed by a specialist.¹¹

The pending Medicaid rules parallel the first three of the four provisions in H.R. 2563. Plans must ensure that “all covered services are available and accessible to enrollees,”¹² provide

⁶42 CFR 422.113

⁷Remarks by the President to the American College of Cardiology Annual Convention. March 21, 2001. <http://www.whitehouse.gov/news/releases/2001/03/20010321-2.html>

⁸H.R. 2563, Section 114(a)(1)

⁹H.R. 2563, Section 114(a)(3)(A)

¹⁰H.R. 2563, Section 114(b)(1)(A)

¹¹H.R. 2563, Section 114(b)(2)

¹²42 CFR 438.206(a)

essential out-of-network services,¹³ and allow “a standing referral” for all patients with special health care needs.¹⁴ The Medicaid rules are more modest than H.R. 2563, however, in that they do not grant a right for chronically ill patients to have their care directed by specialists.

3. Appeals Process

In President Bush’s words, “If medical care is denied, patients should have the right to a fair and immediate review.”¹⁵ H.R. 2563 gives enrollees the right to two types of review of any coverage or benefit decisions: (1) review inside the managed care plan; and (2) review external to the plan by unbiased experts. For the internal review, plans must make a determination within 14 days (or 72 hours in the case of an emergency) in accordance with the medical exigencies of the case.¹⁶ The decision must be made by a health professional not involved in the original denial of care,¹⁷ and patients must be informed of their right to appeal the decision of the internal reviewer.¹⁸

The Medicaid rules also provide for an internal review of benefit or coverage decisions. The rules parallel those in H.R. 2563. Plans must make a determination within 30 days (or 72 hours in case of emergency).¹⁹ The decision must be made by a health professional not involved in the original denial of care,²⁰ and patients must be informed of their right to appeal.²¹

However, unlike H.R. 2563, the Medicaid rules at stake contain no provision for an appeal to experts external to the managed care plan.²²

¹³42 CFR 438.206(d)(2)

¹⁴42 CFR 438.208(f)(3)

¹⁵Remarks by the President to the American College of Cardiology Annual Convention. March 21, 2001. (<http://www.whitehouse.gov/news/releases/2001/03/20010321-2.html>)

¹⁶H.R. 2563, Section 103(b)(3)

¹⁷H.R. 2563, Section 103(c)(2)

¹⁸H.R. 2563, Section 103(d)(3)

¹⁹42 CFR 438.408(c)

²⁰42 CFR 438.406(7)

²¹42 CFR 438.408(f)

²²Medicaid patients have a separate right to a fair hearing.

4. Women's Health

In March, President Bush declared that “women should be able to visit their gynecologist...without going through a gatekeeper.”²³ H.R. 2563 gives women the right to see a “participating health care professional who specializes in obstetrics and gynecology” without requiring authorization or referral from a primary care physician, the plan or any other provider.²⁴

The Medicaid rules also offer direct access to obstetrician-gynecologists by including them in the definition of primary care provider.²⁵

5. Truth in Marketing

To prevent managed care companies from deceiving patients, H.R. 2563 requires plans to provide information each year on benefits,²⁶ cost sharing,²⁷ participating providers,²⁸ preauthorization requirements,²⁹ specialty care,³⁰ prescription drug coverage,³¹ emergency services,³² appeals,³³ translation services,³⁴ and accreditation.³⁵ Plan members can also request

²³Remarks by the President to the American College of Cardiology Annual Convention. March 21, 2001. (<http://www.whitehouse.gov/news/releases/2001/03/20010321-2.html>)

²⁴H.R. 2563, Section 115(a)(1)

²⁵42 CFR 438.2 and 42 CFR 438.206(d)(2)

²⁶H.R. 2563, Section 121(b)(1)

²⁷H.R. 2563, Section 121(b)(2)

²⁸H.R. 2563, Section 121(b)(5)

²⁹H.R. 2563, Section 121(b)(7)

³⁰H.R. 2563, Section 121(b)(9)

³¹H.R. 2563, Section 121(b)(11)

³²H.R. 2563, Section 121(b)(12)

³³H.R. 2563, Section 121(b)(13)

³⁴H.R. 2563, Section 121(b)(16)

³⁵H.R. 2563, Section 121(b)(17)

specifics on individual physicians³⁶ and summaries of methods of compensation.³⁷

The pending Medicaid rules also require annual disclosure of benefits,³⁸ cost sharing,³⁹ participating providers,⁴⁰ preauthorization requirements,⁴¹ specialty care,⁴² prescription drug coverage,⁴³ emergency services,⁴⁴ and appeals.⁴⁵ Patients can request information on translation services,⁴⁶ accreditation⁴⁷ specifics on individual physicians,⁴⁸ and summaries of methods of compensation.⁴⁹

6. Other Provisions

Other provisions in the Medicaid rules are strikingly similar to those in H.R. 2563. For example, both establish protections for patients when coverage is terminated,⁵⁰ and both protect physicians' rights to advocate for their patients.⁵¹

³⁶H.R. 2563, Section 121(c)(1)

³⁷H.R. 2563, Section 121(c)(2)

³⁸42 CFR 438.10(e)(2)(i)

³⁹42 CFR 438.10(e)(2)(ix)

⁴⁰42 CFR 438.10(e)(2)(iv)

⁴¹H.R. 2563, Section 121(b)(7)

⁴²42 CFR 438.10(e)(2)(viii)

⁴³42 CFR 438.10(e)(2)(i)

⁴⁴42 CFR 438.10(e)(2)(xiv)

⁴⁵42 CFR 438.10(e)(2)(x)-(xi)

⁴⁶42 CFR 438.10(f)(3)

⁴⁷42 CFR 438.10(f)(1)

⁴⁸42 CFR 438.10(f)(2)

⁴⁹42 CFR 438.10(f)(5)

⁵⁰Compare 42 CFR 436.62 and H.R. 2563, Section 117

⁵¹Compare 42 CFR 438.102 and H.R. 2563, Section 135

H.R. 2563 also provides additional protections that are not part of the Medicaid rules, including coverage for clinical trials⁵² and the right of families to bring their children to a pediatrician.⁵³

The remaining provisions in the Medicaid rules cover such basic areas as flexibility for rural areas with few health providers,⁵⁴ safeguards for children and adults with special health care needs,⁵⁵ provider discrimination,⁵⁶ conflict of interest safeguards,⁵⁷ solvency standards,⁵⁸ the use of practice guidelines,⁵⁹ and sanctions for noncompliance.⁶⁰ These additional provisions are commonsense rules to protect patients and prevent managed care abuses of millions of vulnerable children, disabled and elderly in the United States.

⁵²H.R. 2563, Section 119

⁵³H.R. 2563, Section 116

⁵⁴42 CFR 438.52

⁵⁵42 CFR 438.208

⁵⁶42 CFR 438.12

⁵⁷42 CFR 438.58

⁵⁸42 CFR 438.116

⁵⁹42 CFR 438.236

⁶⁰42 CFR 438.700